STATE OF VERMONT
BOARD OF MEDICAL PRACTICE

In re: Santiago Cancio-Bello, M.D.	)	Docket No. MPN 74-0702

STIPULATION AND CONSENT ORDER

NOW COME Santiago Cancio-Bello, M.D. (Respondent), and the State of Vermont, by and through Attorney General William H. Sorrell and undersigned Assistant Attorney General James S. Arisman, and agree and stipulate as follows:

1. Santiago Cancio-Bello, Respondent, holds Vermont Medical License Number 042-0005243, issued by the Vermont Board of Medical Practice on March 20, 1974. Respondent practices obstetrics and gynecology in Rutland, Vermont.

2. Jurisdiction vests in the Vermont Board of Medical Practice (Board) by virtue of 26 V.S.A. §§ 1353, 1354 & 1398.

I. Background.

3. The Vermont Board of Medical Practice opened this matter on July 22, 2002 following receipt of a complaint from a patient (hereinafter referred to as Patient A) regarding the results of ovarian surgery performed by Respondent. The patient alleged that during surgery that took place in August 2000 Respondent failed to remove one of her ovaries. The operation, as planned and as she understood it, was to remove both her ovaries. The Board's investigation included review of Respondent's office records, review of hospital and surgical records, interviews with or review of statements from individuals having knowledge of the facts in this matter, receipt of a written response from Respondent, and a meeting with Respondent.

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4. Respondent first provided care to Patient A beginning in 1985. Respondent's care of Patient A over the following years was extensive. Respondent provided routine gynecological care to Patient A, treated her for specific medical conditions, and was her surgeon for several procedures, including a 1991 hysterectomy. Respondent's medical records for Patient A included information regarding her medical history, general physical condition, and various medical problems.

A. Medical Records.

5. The Board reviewed the voluminous medical records covering care provided to Patient A. Respondent's medical records for the patient include an office note from him, dated July 27, 1992, that referred to Patient A's "ovaries" and characterized the patient's "[g]eneral and pelvic examination [as] completely unremarkable." A subsequent report, dated November 24, 1993, of an examination of Patient A by Respondent noted "no abnormalities, both in reference to her general and gynecological exams."

6. In 1993-94, Patient A began experiencing episodic, severe right lower quadrant pain. Her pain persisted, and her family practice physician examined her. Her family practice physician additionally referred her for a diagnostic abdominal CT scan in 1994. The resulting report of CT scan findings noted no congenital abnormality of the patient's reproductive organs. Respondent communicated with both the patient's family practice physician and the radiologist regarding Patient A's 1994 CT scan results. Respondent also discussed the radiological findings with Patient A on two occasions during January 1994.[1] Respondent's office notes and operative report do not describe any congenital abnormality of the patient's reproductive organs.

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1. Subsequently, Patient A underwent laparoscopic removal by Respondent of a dilated right fallopian tube.

II. August 1, 2000 Surgery Performed by Respondent.

7. In 2000 Patient A, then 39 years of age, began to experience bouts of sharp, recurring pelvic pain.[2] The results of a subsequent CT scan on May 22, 2000 include the following entry by the radiologist, indicating the presence of both left and right-side cysts:

> Prominent bilateral adnexal cysts are seen. An adnexal cyst was identified on the right side on the prior exam. The largest septated cyst on the right measures 4 cm. On the left the largest adnexal cystic structure measures 4 cm, as well.

The stated impression is, "Bilateral adnexal cysts of uncertain etiology." The radiology report identified no congenital abnormality of the patient's reproductive organs. Patient A recalls that the radiologist told her that both her ovaries had cysts. A copy of the written radiology report appears in the patient's medical records, as maintained by Respondent, and includes a handwritten note by Respondent and his initials, "CB", indicating that he saw this report.

A. Patient A's Office Visit with Respondent.

8. On or about June 1, 2000 Patient A saw Respondent with her complaint of recurring pelvic pain. Respondent's office note for Patient A for the June 1, 2000 visit states, "CT scan shows bilat. ovarian cysts. See report 5.22.00 - 4 cm Septated cyst in R side." Respondent's office note includes the following plan, "need to investigate Laproscopy - poss. Excision of ovarian cysts. Possible laparotomy + exploration. [signed] CB."

B. Patient's Account of the Office Visit.

9. Patient A recalled her office visit and meeting with Respondent on June 1, 2000 as follows, "We reviewed the results of the cat scan and discussed the pain I was having

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2. Earlier, in January 2000, Patient A had seen a family practice physician for a comprehensive physical examination. She complained at the time of weight gain and abdominal bloating. The physician's examination record states, "She had a partial hysterectomy in 1990 for cervical cancer with both ovaries remaining." (Emphasis added.) The result of the examining physician's "review of systems" was "Unremarkable". The patient's external and internal genitalia were described as "Normal". The examining physician ordered a radiological examination of the patient's "ovaries" as a precaution. A copy of the examining physician's note was included within the patient's records, as maintained by Respondent, as was a copy of the written report on the May 22, 2000 CT scan.

and we decided to remove both ovaries." Patient A specifically recalls reviewing her CT scan and discussing with Respondent how the surgery would be performed. Patient A also recalls that during the meeting she and Respondent made the decision to remove surgically both her ovaries.

10. Patient A denies that there was ever a discussion between Respondent and herself regarding a plan to preserve her ovarian function. In fact, Patient A recalls that she wanted surgical removal of both her ovaries because she believed this would eliminate her recurring pain.[3]

11. On August 1, 2000, the day of her surgery, Patient A went to Rutland Regional Medical Center with a friend named Janice accompanying her. Patient A had told Janice that she (Patient A) had cysts on both her ovaries and that Respondent would be surgically removing both her ovaries that day.

12. Following surgery, Respondent came to speak with Patient A's friend, Janice, who had waited at the hospital during the procedure. Respondent told Janice that he had completed surgery and had removed one ovary from Patient A. Janice then asked Respondent about Patient A's "other" ovary. Respondent replied that Patient A did not have a second ovary. Janice was surprised by Respondent's statement because she been told by Patient A that an earlier CT scan had shown she had two ovaries.

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3. Within Respondent's medical records for Patient A appears a document headed, "CONSENT FORM", and including the following entries, "TITLE OF OPERATION: Laparoscopy - possible excision of ovarian cysts possible laparotomy exploration"; and "DIAGNOSIS: Pelvic pain, bilateral ovarian cysts." The consent form also states, "I am aware of the risks and possible complications of the above surgery as told to me by Dr. Cancio-Bello, and I give my permission for this surgery to be performed." The "consent form" is undated and unsigned by Patient A. Elsewhere in Patient A's medical file is an unsigned, undated surgical booking form that repeats the patient's diagnosis (i.e., "pelvic pain, bilat. ovarian cysts"), the procedure to be performed ("possible excision of ovarian cysts"), and the planned date of the surgery (August 1, 2000).

III. Medical Records and Communications with Patient.

13. A "Short Stay Form" from Rutland Regional Medical Center for Patient A's surgery on August 1, 2000 includes the following handwritten history, "C/O pelvic pain, intermittent, progressive 6-8 wks – CT scans shows bilat. ov. cysts. Pelvic exam confirms". The entry is in Respondent's handwriting and includes his initials in the signature block. Another entry on this form states that a "Provisional Diagnosis of "Pelvic pain. Bilat ovarian cysts".

14. Respondent's written operative report for the August 1, 2000 procedure identified the "operative indications" as including the following, "CT scan revealed the presence of 'bilateral ovarian cysts.' The pelvic examination confirmed the findings." However, Respondent's post-surgical report of operative findings states, "The patient had no left adnexa", (i.e., no left ovary). The written operative report includes no description or indication of any attempt by Respondent, successful or unsuccessful, to visualize the area of the left ovary during the surgical procedure.

A. Patient's Account.

15. Following surgery, Patient A learned from her friend, Janice, that Respondent had removed only her right ovary. The patient's reaction to this information was "[t]otal disbelief." Patient A called Respondent's office on August 2, 2000 and spoke with him by telephone. "I told him that Janice told me he only removed the right ovary and not the left and that I understood that both ovaries [were] going to be removed." Patient A recalls that Respondent told her that she "did not have a left ovary" and stated that she "must have been born without one." Patient A replied, "[W]hat do you mean I don't have a left ovary, it shows in the cat scan and two weeks ago we discussed both ovaries being removed."

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16. Patient A recalls that Respondent told her she did not understand and not to worry. He then prescribed for her "Estrogen pills (Premarin 0.625 mg) one tablet daily." Patient A was confused and concerned by Respondent's prescribing of estrogen. She felt that if she had a remaining ovary, as she believed, she did not need to take the estrogen that had been prescribed for her by Respondent.[4]

17. Patient A later made an appointment to see Respondent at his office. Prior to the meeting Patient A gathered copies of her medical records and CT films.

18. On August 30, 2000, Patient A met with Respondent. She recalls, "He said again that maybe I was born without one [i.e., a second ovary]. But I reminded him that we had talked about removing them both." Patient A recalls that Respondent became "defensive" and denied that he had discussed with her the removal of both her ovaries. She recalls, "He said he checked the left side but found no ovary. He repeated this several times."

19. Patient A states that during the August 30, 2000 meeting Respondent "never looked at my films and never gave me an internal check up to see if I still had the left ovary."

20. Nonetheless, Patient A states that at her insistence Respondent yielded and agreed to have his staff schedule an ultrasound for her for September 1, 2000. Patient A recalls, however, Respondent told her that she had no need for another ultrasound examination because it would not show that she had a second ovary.[5]

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4. Estrogen (sodium estrone sulfate and sodium equilin sulfate) is indicated following removal of both ovaries or after primary ovarian failure. Physician's Desk Reference (PDR) at 3444-47 (57th ed. 2003). The PDR warns, "A complete medical and family history should be taken prior to the initiation of any estrogen therapy. The pretreatment and periodic physical examinations should include special reference to blood pressure, breasts, abdomen, and pelvic organs, and should include a Papanicoleau smear."

5. Patient A recalls that Respondent told her "the [earlier] cat scan could have been wrong" and that he had the last say in the situation.

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21. Subsequent ultrasound examination on September 1, 2000 verified that Patient A, in fact, had a left ovary. When Patient A spoke with Respondent regarding the results of the CT scan, she recalls he told her that her abdominal discomfort and pain were not from her remaining ovary. She asked Respondent if she still needed to take the Estrogen he had prescribed for her. He did not answer her question and told her to come back for a follow-up visit in three months. After this meeting, Patient A lost confidence in Respondent and transferred her medical care to another physician.

22. Patient A later received a telephone call from Respondent. She recalls Respondent telling her that he was sorry that things had turned out as they had. She recalls Respondent stating without elaboration that "the problem was miscommunication" and that he had made a "mistake".

B. Respondent's Account.

23. Respondent states that his original understanding with Patient A regarding her surgery was that he was to preserve her "ovarian function", if possible.[6] He states that on the day of the operation, "there was no cyst or pathology in her left ovary that warranted its removal." He stated, "My mistake was to sign my operative note without reading it. If I had done so I would have seen that under the paragraph: 'OPERATIVE FINDINGS', I wrote 'the patient had no left adnexa'. It should have read: the pt [patient] had no left adnexal cyst or pathology."

24. The Board of Medical Practice received directly from Respondent during its investigation of this matter a copy of Respondent's operative report in which the word "cyst"

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6. Respondent's office note for his June 1, 2000 pre-surgical visit with Patient A does not indicate that any discussion took place regarding possible preservation of the patient's ovarian function.

had been inserted in handwriting above the word "adnexa" in the typed operative findings. Respondent later explained that he inserted the word "cyst" in the copy of the operative report he provided to the Board during its investigation. Respondent stated that the word "cyst" had been inadvertently omitted from the typed operative report due to a transcription error.[7]

25. Respondent states that his telephone conversation with Patient A on August 2, 2000, the day after her surgery, occurred as follows, "When she called for her operation details she obviously did not remember what I told her right after surgery."[8] He states, "At the moment of her call I was in the middle of office hours, a very busy afternoon. When I read the operative note I could not make any sense of it and did not have time to go through the chart in detail." Respondent elaborated that he was "momentarily confused" at the time of Patient A's telephone call to him and that he "had not had a chance to remember clearly in my in mind what was on the report."

26. Respondent regards the circumstances related to Patient A's surgery as regrettable and the result of poor communication on his part.

C. Patient A's Subsequent Medical Care and Surgery.

27. After her August 30, 2000 meeting with Respondent, Patient A transferred her care to another Rutland-area surgeon. According to Patient A and the content of her medical records, she continued to experience persistent left-sided abdominal pain.

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7. It is the Board's position that an undated, unsigned, subsequent insertion of material information in a written medical record by a practitioner is improper and misleading and that such an after-the-fact entry does not conform to generally accepted standards for the creation, maintenance, and correction of written patient medical records.

8. The patient's medical records do not include any written entry reflecting that post-surgical communication took place between Patient A and Respondent.

28. On December 8, 2000, Patient A's new surgeon performed a laparotomy for lysis of adhesions and removal of the patient's left ovary. The new surgeon's operative report stated, "Using hand-held retractors, we were able to visualize the region of the left adnexa which appeared to be the cystic left ovary. There were multiple adhesions between the ovary and the bowel. These were bluntly and sharply lysed as needed."

29. The post-operative pathology diagnosis stated, "Left ovary, oophorectomy: BENIGN CYSTIC FOLLICLES AND CORPORA LUTEA". Sectioning of the ovary revealed "several cystic corpora lutea".

30. Since the above surgery, i.e., removal of her left ovary on December 8, 2000 by her new surgeon, Patient A has not experienced further left lower abdominal pain.

IV. State's Allegations.

31. Investigation of this matter by the Board of Medical Practice determined that in his care of Patient A Respondent on more than one occasion failed to meet the required standard of medical care. Specifically, the State alleges:

a. Respondent failed to adequately review before and at the time of surgery pertinent available medical records and CT scan results regarding Patient A's history and physical condition;

b. Respondent's pre-operative surgical planning failed to adequately document in the office record whether one or both of the patient's ovaries were to be removed and whether there was any intention or agreement with the patient as to any plan to preserve "ovarian function"; hospital documentation for the surgery, as prepared by Respondent, reflects the same lack of clarity;

c. the hospital surgical consent forms prepared for the patient's signature are unclear and imprecise as to the specific nature of the operation to be performed by Respondent;

d. Respondent's records for Patient A fail (i) to document what he and the patient had discussed and agreed to regarding the surgical procedure that was planned;

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and (ii) fail to document clearly the content of any communications between them with regard to any discussion of possible intraoperative options that might have been available to her;

e. the operative record prepared by Respondent is unclear and inadequate in that it (i) fails to address Respondent's plan of care for and actions taken by him with regard to the patient's left ovary; and (ii) provides no detail, information, or description of any kind regarding the patient's left ovary; Respondent's after-the-fact hand-written entry of the word "cyst" into his operative report and presentation of the report in this form to the Board during its investigation was inconsistent with applicable professional standards and misleading;

f. one or more of the deficiencies cited above led to the performance by Respondent of an incomplete procedure, contrary to the patient's expectations, that ultimately led to another major surgery for the patient that she had never contemplated; and

g. Respondent's post-surgical communications with his patient at his office reflect a failure by him to carefully and adequately review her medical records and clearly and accurately address with her the nature of the operative procedure that was originally to have been performed, the patient's expectations, and the results that actually occurred.

V. Sanction: Order of Public Reprimand; Conditions of Licensure.

32. Respondent has cooperated fully with all phases of the Board's investigation of this matter. In response to his concerns regarding this matter, Respondent indicates that he already has voluntarily implemented certain corrective steps with regard to his medical record keeping and office procedures.[9]

33. Respondent disputes certain aspects of the State's recitation of facts in Paragraphs 7 through 22, above, and certain of the State's specific allegations as set forth in Paragraph 31, above. However, Respondent has determined that to resolve with finality the

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9. Respondent reports that he has increased the time he spends with patients during office visits. To avoid distracting interruptions, Respondent's office staff write down incoming telephone messages from patients and at a later time provide Respondent with a copy of the written message along with the patient's chart. Respondent reviews all incoming messages after office visits by patients have been concluded. He or office staff make return calls to patients, responding to individual questions or concerns. Respondent also has initiated use of a new surgical consent form that requires signatures from the patient, Respondent, and a witness. Respondent indicates that he also has become a public advocate with his peers for the continuous review of operative systems and record keeping procedures to reduce errors, increase reliability, and improve patient care.

matter now before the Board, he will not to contest the State's allegations in their particulars. Respondent agrees that certain aspects of his care of Patient A were not consistent with the applicable standard of medical care and that this circumstance provides a factual and legal basis for the instant agreement.[10]

34. Respondent acknowledges that had the State of Vermont filed a specification of charges in this matter and satisfied its evidentiary burden as to its allegations at a public hearing, the Board could have entered findings adverse to him, under 26 V.S.A. § 1354 and/or § 1398, in light of the facts set forth above. Respondent agrees that the Board of Medical Practice may enter as its findings and/or conclusions Paragraphs 31 through 34 of this agreement, thus providing a legal basis for the actions agreed to herein by the parties.

35. The parties to this Stipulation and Consent Order agree that appropriate disciplinary action in this matter shall consist of the following:

A. Respondent's license to practice medicine shall be designated as "conditioned"; Respondent shall comply fully and in good faith with each of the terms and conditions of licensure expressly set forth below, wherever he may practice, until such time as he has been relieved of these conditions by express written order of the Vermont Board of Medical Practice.

B. A substantial or repeated failure by Respondent to comply with any of the terms and conditions herein may constitute unprofessional conduct and may result in such disciplinary action as the Board may deem appropriate under the circumstances.

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10. During the Board's investigation, Respondent provided a written expert review that raised question as to whether there was a cyst on the patient's left ovary that would have required surgical intervention during the August 2000 procedure that was performed by Respondent. The expert observed that the post-surgical pathology report, which was prepared following removal of the left ovary during the subsequent December 2000 surgery, described an ovary of normal size, without cystic mass, and with benign cystic follicles and corpora lutea. In the expert's opinion, the condition of the overy as described would not have required surgical removal. The expert's opinion was that "no harm" had been done to the patient, "except that she did require an additional surgical procedure." The investigative committee disagreed with this opinion. The investigative committee concluded from the record in this matter that the necessity of an "additional surgical procedure" was an outcome that the patient specifically had sought to avoid.

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C. Respondent shall be publicly **REPRIMANDED** by the Vermont Board of Medical Practice for the conduct set forth above, in addition to the imposition of the terms and conditions set forth herein and below.

VI. Conditions of Licensure.

A. Record Keeping.

36. Respondent agrees as a condition of licensure that for at least 24 months following the effective date of this agreement that he shall prepare and make available to the Board for its review the following:

a. a copy of the clear, detailed written surgical plan prepared by Respondent, taken from either the office or hospital record for each surgery performed by him;

b. a copy of a clear and detailed written surgical consent document(s) prepared by Respondent and signed and dated by the patient and Respondent for each surgery to be performed by Respondent;

c. a copy of the post-surgical written operative report prepared by Respondent for each surgery performed by Respondent;

d. a copy of the post-surgical pathology report for each procedure, if one has been prepared; and

e. a copy of the written discharge summary prepared by Respondent for each patient surgery performed by Respondent.

37. The specified records for each surgical patient, as specified above, shall be individually collated and, upon request, promptly forwarded to the Board of Medical Practice or otherwise made available for review. Absent proceedings under 26 V.S.A. § 1355, the identity and medical records of each patient shall be treated as confidential by the Board.

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B. Continuing Medical Education: Record Keeping.

38. Respondent agrees that he shall promptly attend and successfully complete (a) the on-site, two-day intensive course in medical record keeping which is offered by the School of Medicine of the Case Western University; and (b) the program's additional chart review and feedback activities that occur at three months and six months after completion of the on-site course. Respondent agrees that his attendance at the two-day on-site intensive course shall take place as soon as practicable during the year 2004, i.e., on June 3-4, 2004 or November 4-5, 2004 and no later. Respondent agrees that he shall document his attendance and successful completion of this coursework by prompt submission to the Board of appropriate certification, documentation, and/or evaluation of his coursework. Respondent shall bear all costs.

39. The above coursework must be eligible for credit as "continuing medical education" and be eligible for total credits of at least 17.5 hours in Category I of the Physician's Recognition Award of the American Medical Association. Respondent's participation must earn the full 17.5 hours of credits for such course work. Respondent shall be responsible for ensuring that documentation of and evaluations of Respondent's participation in and satisfactory completion of such coursework are promptly forwarded to the Board of Medical Practice for its review. Such documentation must be provided in a manner and form satisfactory to the Board and in no case later than 30 days after Respondent's completion of coursework. Respondent shall bear all costs.

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VII. Other Matters Related to Implementation.

40. No specification of charges has been filed by the State in this matter. Respondent has not previously been the subject of disciplinary action by the Board.

41. Respondent acknowledges that he is knowingly and voluntarily agreeing to this Stipulation and Consent Order. He acknowledges that he has had advice of counsel regarding this matter and in reviewing this Stipulation and Consent Order. Respondent is fully satisfied with the legal representation he has received in this matter. He agrees and understands that by executing this document he is waiving any right to be served with formal charges, to challenge the jurisdiction and continuing jurisdiction of the Board in this matter, to be presented with the evidence against him, to cross-examine adverse witnesses, and to offer evidence of his own to contest the State's charges.

42. Respondent agrees that he has read and carefully considered all terms and conditions herein and agrees to accept and be bound by these while licensed to practice medicine in the State of Vermont or elsewhere. He agrees to be bound by these until such time in the future as he may be expressly relieved of these conditions, in writing, by the Vermont Board of Medical Practice. The Board shall consider a petition from Respondent for relief from or modification of these conditions, no sooner than 24 months after the effective date of this Stipulation and Consent Order, and in its sole discretion may approve or disapprove such a petition following review of Respondent's compliance with this agreement.

43. Respondent's license to practice medicine in the State of Vermont shall be conditioned for a minimum of two years, following entry of the Board's order approving the terms of this agreement. Respondent's Vermont medical license shall bear the designation "Conditioned" until such time as all terms and conditions upon his license have been removed by order of the Board.

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44. The parties agree that this Stipulation and Consent Order shall be a public document, shall be made part of Respondent's licensing file, and may be reported to other

licensing authorities and/or entities including, but not limited to, the National Practitioner Data Bank and the Federation of State Medical Boards.

45. During the period that Respondent's license is conditioned he shall comply fully with all the requirements set forth herein. Respondent expressly agrees that any failure by him to comply with the terms of this Stipulation and Consent Order, specifically including but not limited to its review and/or submission requirements, may constitute unprofessional conduct under 26 V.S.A. §1354(25) and may subject Respondent to further disciplinary action.

46. This Stipulation and Consent Order is subject to review and acceptance by the Vermont Board of Medical Practice and shall not become effective until presented to and approved by the Board. If the Board rejects any part of this Stipulation and Consent Order, the entire agreement shall be considered void. However, the parties agree, that should the terms and conditions of this Stipulation and Consent Order be deemed acceptable, the Board may enter an order conditioning Respondent's license to practice medicine as set forth above, that such license shall be subject to the terms and conditions set forth above. Further, such order shall provide that **Santiago Cancio-Bello, M.D., Respondent, shall be and hereby is publicly REPRIMANDED** by order of the Vermont Board of Medical Practice for the reasons set forth above.

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medicine as set forth above, that such license shall be subject to the terms and conditions set forth above. Further, such order shall provide that **Santiago Cancio-Bello, M.D., Respondent, shall be and hereby is publicly REPRIMANDED** by order of the Vermont Board of Medical Practice for the reasons set forth above.

JSA

Dated at Montpelier, Vermont, this 3rd day of MARCH, 2004.

STATE OF VERMONT
WILLIAM H. SORRELL
ATTORNEY GENERAL

by: _____
JAMES S. ARISMAN
Assistant Attorney General

Dated at Rutland, Vermont, this 3rd day of March, 2004.

_____
SANTIAGO CANCIO-BELLO, M.D.
Respondent

Dated at Montpelier, Vermont, this 3rd day of March, 2004

_____
PETER B. JOSLIN, ESQ.
Counsel for Respondent

Dated at Montpelier, Vermont, this _____ day of _____, 2003.

STATE OF VERMONT

WILLIAM H. SORRELL
ATTORNEY GENERAL

by: _____
JAMES S. ARISMAN
Assistant Attorney General

Dated at _____, Vermont, this ____ day of _____, 2003.

_____
SANTIAGO CANCIO-BELLO, M.D.
Respondent

Dated at _____, Vermont, this ____ day of _____, 2003.

_____
PETER B. JOSLIN, ESQ.
Counsel for Respondent

* * *

FOREGOING, AS TO SANTIAGO CANCIO-BELLO, M.D.
APPROVED AND ORDERED
VERMONT BOARD OF MEDICAL PRACTICE

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DATED: 3/3/04

ENTERED AND EFFECTIVE: March 3, 2004

Stip/Consent: Santiago Cancio-Bello, M.D.; JSA; Not Approved by BMP Until Executed and Entered Above

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